Veterans Health Administration

Reference Manual
for

Telehealth Coding

Workload Credit, Billing, and Reimbursement

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C O N T E N T S

A P P E N D I C E S

Section A. Background and Definitions

A.1 Background

Telemedicine involves "the use of electronic information and communications technologies to provide and support health care when distance separates the participants"[1]. Telemedicine may be considered as a set of processes that facilitate the delivery of treatments or procedures to patients at a distance making it distinct from the treatment or procedure itself[2]. For the purposes of this document telemedicine is intrinsically bound to the care delivery process and should be considered part of a "package of care". The purpose of this manual is to provide a systematic guide to the coding, workload credit and reimbursement of telemedicine/telehealth within VHA. This will include meeting both the VHA's Decision Support System (DSS) and the Centers for Medicare and Medicaid Services (CMS) requirements. Coding and reimbursement for telemedicine/telehealth is an evolving area of health care development and it is anticipated that this document will require ongoing update to reflect this evolutionary process.

A.2 Definitions

Telemedicine/telehealth - Consultation: is the provision of advice on a diagnosis, prognosis, and/or therapy using telemedicine, but hands-on care is delivered by a licensed independent health care provider located at the site of the patient (OS). The actual care of the patient, or action on the advice, is performed by a licensed independent provider at the OS who determines the appropriateness of the advice for action, i.e., a cardiology consultation where a licensed independent provider at the site of the patient implements the advice through orders or other means and then monitors the status of the patient. Consultation is therefore when the consultant involved in providing telemedicine/ telehealth recommends diagnoses, treatments, etc., to the provider requesting the consult, but does not actually write orders or assume the care of the patient (note: this is in accordance with the DSS definition of Consultation as a type of Evaluation & Management service provided by a clinician whose opinion or advice regarding evaluation and/or management of a specific problem is requested by another clinician).

Telemedicine/telehealth – Care: is the provision of advice on a diagnosis, prognosis, and/or therapy using telemedicine where part of the care delivered at the site of the patient (OS) is authorized by the licensed independent health care provider at the DS. Care is therefore when the provider at the DS recommends diagnoses, treatments, etc., to the OS and actually writes orders or assumes, all or part of, the care of the patient.

Originating Site (OS): is the site where the patient is physically located at the time the telemedicine service is provided. It is the site requesting consultation advice or care management support from a provider located at the distant site (DS). Each episode of care that is coded at an OS must be paired with the

corresponding component of care that is coded at the DS. An OS site may be a CBOC, VET Center or VAMC.

Distant Site (DS): is the site where the provider providing the professional service is located. The DS may be one of 2 kinds. The first kind of DS is one where the DS shares the same STA3 (Station Number) as the OS e.g., a CBOC affiliated with a VAMC. The second type of DS is one where the DS and the OS have different STA3's (Station Numbers) e.g., a CBOC and a VAMC within the same VISN are not affiliated or where the DS and OS are in separate VISN's.

Real Time Telemedicine/Telehealth: Data acquisition, processing, transmission and presentation of patients/patient data are all occurring simultaneously. This term means there is synchronous communication between the parties at either end of the telecommunications link.

Store and Forward: The asynchronous transmission of information, e.g. in the form of still images, audiovisual clips, or other multi-media clinical data derived from a clinical encounter by a practitioner to an intermediate storage device from which the data can be retrieved by another practitioner at a later time for the purposes of providing a consultation or report.

DSS: Decision Support System provides information to support VHA business needs including: multi-pay or revenue determination; product and case-costing; resource utilization tracking; quality indicators; retrospective review of groups of cases for various quality protocols, reimbursement modeling and annual VA medical center and Veterans Integrated Services Network (VISN) budgeting.

DSS Consultation Requirements: There must be a documented request from another source/clinician in the medical record. The consultant must document his/her opinion, advice, and/or testing or treatment of the patient. Documentation must indicate the consultant's findings were communicated back to the requesting clinician.

DSS Identifier: A DSS Identifier is a VHA term that characterizes VHA Ambulatory Care Clinics by a three-character or, in certain instances, six-character descriptor. The DSS Identifier value is transmitted to the National Patient Care Database (NPCD) with each separate outpatient encounter into the NPCD field "DSS Identifier." A three-character primary stop code alone or in combination with a three-character secondary stop code comprises the DSS Identifier.

DSS Primary Stop Code: The first three characters of the DSS Identifier represent the primary stop code. The primary stop code designates the main Ambulatory Care Clinical Group or production unit responsible for the clinic. Three numbers must always be in the first three characters of a DSS Identifier for it to be valid. A complete list of DSS codes is available online at http://www.va.gov/publ/direc/health/direct/12003040.pdf

DSS Secondary Stop Code: Also known as 'Credit Pair', in certain instances the last three characters of the six-character DSS Identifier contain the secondary stop code that serves as a modifier to further define the primary work group. The VA medical center uses the secondary stop code, when appropriate, as a modifier of the work in the primary Ambulatory Care work unit (primary stop code). A complete list of DSS codes is available online at http://www.va.gov/publ/direc/health/direct/12003040.pdf

DSS Telehealth Stop Codes: VHA Telemedicine and Coding Council have created DSS telemedicine Stop Codes (modifiers). See Appendix 15.

DSS Alpha Code: National Suffixes for use with DSS Identifier Credit Pairs as Feeder Keys for DSS Intermediate Products.

Workload Credit: The process whereby DSS stop codes are attached to clinical activity for the purposes of recording numerical data on ambulatory and outpatient episodes. Workload is the appropriately recorded activity of a patient service provided by a VA health care provider. Workload may also be referred to as patient encounter, patient visit or occasion of service. For additional information, please refer to VHA Directive 2002-023 Ambulatory Care Data Capture on line at http://www.va.gov/publ/direc/health/direct/12002023.pdf.

Non-Count vs. Count Clinic: A clinic in VISTA is set up as a non-count clinic or a count clinic. A non-count clinic will not be included in any workload measure. A count clinic will be included in workload statistics.

Encounter: An encounter is a professional contact between a patient and a practitioner vested with primary responsibility for diagnosing, evaluating and/or treating the patient's condition.

Occasion of service: A specific identifiable act or service involved in the medical care of a patient independent of a visit that does not require independent, clinical judgment as to the patient's care

Visit: An episode of care in one or more clinics within a calendar day.

Healthcare Common Procedural Coding System (HCPCS – Including CPT, G and Q codes, and GQ/GT modifiers): Is a national coding system developed by CMS to standardize coding systems used to process Medicare claims. HCPCS has been selected for use in the HIPAA transactions. The HCPCS is a coding system to primarily bill for supplies, materials and injections. It is also used to bill for certain procedures and services that are not defined in CPT. HCPCS is a three level coding system which incorporates CPT, national and local level codes. HCPCS *Level I* involves numeric CPT codes that are maintained by the AMA. HCPCS *Level II* contains alphanumeric codes used to identify various items and services that are not included in the CPT medical code

set. These are maintained by CMS, the BCBSA, and the HIAA. The (Level II) G codes are used to identify professional health care procedures and services that would otherwise be coded in CPT but for which there are no CPT codes. The (Level II) Q codes are used to identify professional health care services that would not be coded in CPT code (e.g., drugs, biologicals, and other types of medical equipment or services) but require a code for claims processing purposes. HCPCS *Level III* codes were assigned and maintained by individual state Medicare carriers and have not been allowable for medical reimbursement reporting since October 16, 2002.

NPCD: National Patient Care Database is part of VA's Austin Automation Center in Austin, TX that acts as a repository for all reported VHA health care activity coded by HCPCS codes.

VERA: Veterans Equitable Resource Allocation model is an evolving tool used, by the VA's Allocation Resource Center, for purposes of reimbursing each of VHA's 21 Veterans Integrated Service Networks for the care they deliver each fiscal year. ARC determines reimbursement rates by assessing annual workload reported in NPCD and thereby assigning every patient treated, by each VISN, to either the Basic Care or Complex Care funding (reimbursement) group. Due to associated workload, the ARC reimbursement rate for Complex Care patients is higher than that for Basic Care patients. Currently, there are 26 patient classifications (e.g. AIDS, HBPC, PTSD, SCI, etc.) within the Complex Care funding group. Each of the 26 Complex Care patient classifications has its own minimum requirements.

ECS: Event Capture System provides the ability to capture workload data. ECS was designed primarily for capturing inpatient workload, but it is also used in areas like telehealth where suitable methods of data capture do not exist. According to the DSS, capturing data is important for examining the distribution of workload among care providers, identifying the served population, and determining the excess or lack of capacity for providing services.

Section B. Real-Time Telemedicine (Videoconferencing)

For real-time video conferencing the following Telemedicine Stop Codes for DSS have been developed by the VHA Telemedicine and Coding Council (see Appendix 5).

DSS Modifier	Description
690	Where the patient is
692	Where the provider is, if same station (STA3) as patient
693	Where the provider is, if different station (STA3) than patient

The usual methods of coding, workload capture and reimbursement that apply to all real-time telemedicine activity (**except** telemental health) will be presented first in B.1 – B.1.c. In B.2 – B.2.e, the different requirements for telemental health will be outlined. For technical reasons involved in the capture of VHA workload for telemental in CBOC's these modifiers are used in a different way.

B.1. Real-Time (Videoteleconferencing) Telemedicine - Except Ongoing Telemental Health Telemedicine

B.1.a. Originating Site (OS) Requirements

The patient presenting OS is the site requesting consultation advice or care management support from a provider located at the Distant Site (DS.) Each episode of care that is coded at an OS must be paired with the corresponding component of care that is coded at the DS.

Pre-Encounter/Clinic Scheduling Set Up Requirements

First, the OS (either VAMC or CBOC) Medical Administration Service (MAS) registers OS patient, establishes the telemedicine/telehealth episode as a "count clinic" and sets up the encounter form in VISTA.

If OS/DS Inter-Facility Consult (IFC) teams have established an IFC:

- OS consult is automatically entered into the DS CPRS
- OS patient is automatically registered in DS VISTA
- OS automatically alerted if DS issue requires IFC team resolution
- OS provider (or designee) presents patient to DS provider
- OS automatically alerted when consult complete
- DS report (including Provider Identification) automatically sent to OS CPRS
- OS may view DS report using CPRS Action menu's Display feature

If IFC has not been established:

- OS alerts DS of consult
- DS accesses OS VISTA and replicates OS patient schedule in DS VISTA

- If DS cannot access OS VISTA, OS and DS coordinate patient schedule
- OS provider (or designee) presents the patient to the DS provider.
- DS alerts OS of completion of consult or care service
- DS sends report (including Provider Identification) to OS

Post-Encounter/Clinic Documentation Requirements
Next OS updates patient record using progress note in CPRS and records the appropriate CPT and ICD-9 code in VISTA (see Appendix 6).

For example, for neurology:

Code set	Description
99201-99215GT	TeleNeurology office/outpatient visit
99241-99275GT	TeleNeurology consultation

Finally, OS checks patient 'out' using the Appointment Management function and completes the patient encounter form to document the telemedicine clinic for the patient record as well as for billing and reimbursement purposes.

Billing Requirements
Based on the CPT and ICD-9 coding, the next step is to bill for this clinic. OS will always use HCPCS's code Q3014 (Medicare Part B[3] payment for facility fee) for all telemedicine encounters. OS may use additional HCPCS codes for both inpatient and outpatient services provided (e.g., shave a lesion) in addition to facility fee code Q3014. Q3014 is not associated with either the Diagnostic Related Group (DRG) or the Outpatient Prospective Payment System (APCS/OPPS) billing/payment methodologies, and is therefore (according to Transmittal AB-01-69[4]) paid outside of or in addition to fees charged under DRG or OPPS/APCS. Furthermore, Q3014 is billable/payable for multiple visits by a single patient during a single day. If the OS is designated as the Prospective Payment System (PPS) site, then the OS must bill the 1st party for a co-pay and the 3rd party for the facility fee. For additional information about the use of the Q3014 code please visit the CMS Web site[5].

DSS Workload Credit Coding Requirements
In order to receive VHA's VERA Workload Credit, OS must use the DSS Identifier 690 as a secondary stop code/credit pair for all telemedicine clinics.

For teleneurology OS enters the DSS primary code for neurology (i.e., 315) paired with the DSS secondary code for telemedicine (i.e. 690) resulting in the teleneurology code 315690.

Every procedure for the patient needs to be coded and it may be necessary to consider multiple visits on one day.

B.1.b. Distant Site (DS) Requirements – STA3 (Station Number) same as OS

The distant site (DS) is the site providing the specialist consultation advice or care to the OS. Each episode of care that is coded at a DS must be paired with the corresponding component of care that is coded at the OS.

Pre-Encounter/Clinic Scheduling Set Up Requirements
First, the DS (either VAMC or CBOC) establishes the telemedicine/telehealth episode as a "count clinic."

If OS/DS Inter-Facility Consult (IFC) teams have established an IFC:
- DS CPRS automatically receives consult from OS entry
- DS VistA automatically receives patient registration from OS entry
- If needed, DS IFC team resolves any IFC glitches with OS IF C team
- DS provider provides consult or care to patient and/or OS provider (or designee)
- DS completes consult and automatically alerts OS
- DS report (including Provider Identification) automatically sent to OS CPRS
- DS may view DS report using CPRS Action men u's Display feature

If IFC has not been established:
- DS alerted by OS of consult
- DS accesses OS VistA and replicates OS patient schedule in DS VistA
- If DS cannot access OS VistA, DS and OS coordinate patient schedule
- DS Medical Administration Service (MAS) or IT staff registers patient in DS VistA
- DS provider provides care or consult to patient and/or OS provider (or designee)
- DS (for initial visits) documents what transpired using CPRS 'Consult' feature
- DS (for follow-up visits) documents what transpired using CPRS 'Progress Note' feature
- DS alerts OS of completion of consult or care service
- DS sends report (including Provider Identification) to OS

Post-Encounter/Clinic Documentation Requirements
DS and OS document what transpired at respective sites usin g progress notes in CPRS. DS records the appropriate ICD-9, CPT codes and HCPCS modifier, GT, for professional component of Real Time Telemedicine/Telehealth in VistA. Finally, DS checks patient 'out' using the Appointment Management function and completes the patient encounter form to document the telemedicine clinic for the patient record as well as for billing and reimbursement purposes.

Billing Requirements
Based on the CPT and ICD-9 coding, the next step is to bill for this clinic. If the DS is designated as the Prospective Payment System (PPS) site, then the DS bills the 3rd party for the professional fee. In order to avoid double billing, the DS must switch off (using the 6-character code) any 1st party co-pay billing. The DS never bills the patient (1st party) for the clinic; instead, as outlined in Section B.1, the OS bills the patient for any 1st party co-pay.

DSS Workload Credit Coding Requirements
In order to receive VHA's VERA Workload Credit, DS must use the DSS Identifier 692 as a secondary stop code/credit pair for all telemedicine clinics when the DS shares the same STA 3 (station number) as the OS.

B.1.c. Distant Site (DS) Requirements – STA3 (station number) differs from OS

The distant site (DS) is the site providing the specialist consultation advice or care to the OS. Each episode of care that is coded at a DS must be paired with the corresponding component of care that is coded at the OS.

Pre-Encounter/Clinic Scheduling Set Up Requirements
First, the DS (either VAMC or CBOC) establishes the telemedicine/telehealth episode as a "count clinic."

If OS/DS Inter-Facility Consult (IFC) teams have established an IFC:
- DS CPRS automatically receives consult from OS entry
- DS VISTA automatically receives patient registration from OS entry
- If needed, DS IFC team resolves any IFC glitches with OS IFC team
- DS provider provides consult or care to patient and/or OS provider (or designee)
- DS completes consult and automatically alerts OS
- DS report (including Provider Identification) automatically sent to OS CPRS
- DS may view DS report using CPRS Action menu's Display feature

If IFC has not been established:
- DS alerted by OS of consult
- DS accesses OS VISTA and replicates OS patient schedule in DS VISTA
- If DS cannot access OS VISTA, DS and OS coordinate patient schedule
- DS Medical Administration Service (MAS) or IT staff registers patient in DS VISTA
- DS provider provides care or consult to patient and/or OS provider (or designee)
- DS alerts OS of completion of consult or care service
- DS sends report (including Provider Identification) to OS

Post-Encounter/Clinic Documentation Requirement
If the consult was a 'follow-up' then the DS updates the patient record using progress notes in CPRS, otherwise the OS writes the progress note. DS records the appropriate ICD-9, CPT codes or HCPCS modifier, GT, for professional component of Real Time Telemedicine/Telehealth) in VISTA. Finally, DS checks patient 'out' using the Appointment Management function and completes the patient encounter form to document the telemedicine clinic for the patient record as well as for billing and reimbursement purposes.

Billing Requirements
Based on the CPT and ICD-9 coding, the next step is to bill for this clinic. If the DS is designated as the Prospective Payment System (PPS) site, then the DS bills the 3rd party for the professional fee. In order to avoid double billing, the DS must switch off (using the 6-character code) any 1st party co-pay billing. The DS never bills the patient (1st party) for the clinic, instead, as outlined in Section B.1, the OS bills the patient for any 1st party co-pay.

DSS Workload Credit Coding Requirements
In order to receive VHA's VERA Workload Credit, DS must use the DSS Identifier 693 as a secondary stop code/credit pair for all telemedicine clinics when the DS STA 3 (station number) differs from that of the OS.

Notes:
1. No fee sharing can take place
2. No telepresenter is required at the OS for Medicare purposes. Details of Medicare telemedicine requirements are available on line[5]

B.2. Ongoing VHA Telemental Health Care via Videoteleconferencing

B.2.a. Originating Site Requirement - Exclusive (DS completes OS Requirement, No corresponding DS record required)

Pre-Encounter/Clinic Setup Scheduling Requirements
Note: unlike other real-time telemedicine, for ongoing VHA telemental health care, the Distant Site (DS) mental health provider (usually based at the main VA Medical Center) uses OS VISTA to set-up encounter form and schedule the telemental health clinic in the provider's clinic setup at the Originating Site (OS) where the patient is located.

Post-Encounter/Clinic Documentation Requirement
After the patient is seen, the DS mental health provider updates the patient record using the progress note in CPRS and records the appropriate CPT and/or ICD-9 diagnosis code in VISTA (see Appendix 4).

Code	Description of usage
90804-90809	Office Psychiatry/Individual Psychotherapy with E&M component (Note: psychologist cannot use codes 90805, 90807, 90809 in this series due to E&M component)
90862	Pharmacologic Management
99241-99275	Consultations

The DS mental health provider checks the patient "out" using CPRS's Appointment Management function and completes the patient encounter form to document the telemedicine clinic for the patient record, as well as for billing and reimbursement purposes.

Notes:

1. No recording at the DS is needed, since the DS mental health provider enters information into the OS-based telemental health clinic record (i.e., DSS 502690)
2. No fee sharing can take place
3. No telepresenter is required at the OS for Medicare purposes. Details of Medicare telemedicine requirements are available online[5]

Billing Requirements

Based on the CPT or ICD-9 coding, the next step is to bill. DS always uses HCPCS's code Q3014 for OS facility fee for Medicare Part B payment. For the professional fee, DS uses the appropriate CPT code as listed in B.1.c. above (e.g., 90804) for the service provided and uses the GT telehealth modifer (e.g., 90804GT) to indicate the service was provided 'via interactive audio and video telecommunications systems.' For additional information about the use of Q3014 and the GT modifier please visit the CMS Web site[5]. The DS VAMC Medical Care Collection Fund (MCCF) bills the third party payor. Only the OS can bill for the Co-Pay, providing this is indicated.

DSS Workload Credit Coding Requirement - Entered exclusively at Originating Site (OS)

The DS provider schedules at the OS by pairing the DSS primary 'Mental Health' Stop Code ('500' series, usually 502) with either the DSS secondary 'Telemedicine' Stop Code 690 or 692 (see Appendix 4). The 690 modifier is used if no co-therapist (i.e., RN or Rehabilitation Specialist) is present at OS with patient, or 692 if a co-therapist is with patient at OS) to yield e.g., 502690 or 502692 to document the telemental health clinic with the provider at the DS.

A co-therapist (i.e., RN or Rehabilitation Specialist), with patient at OS, schedules at the OS by pairing the DSS primary 'Mental Health' Stop Code (usually 502) with the DSS secondary 'Telemedicine' Stop Code 690.

DSS maps the DS telemental health provider's time, in DSS, to this telemental health clinic at the OS. This clinic should be a count clinic in OS (the CBOC's) MAS.

B.2.b. Exception 1: VHA to Vet Center Telementa l Health

In the situation where a VAMC or CBOC provides a Vet Center with telemental health services, DSS workload needs to be mapped to the VHA facility using DSS's secondary stop code 693 as described in Section B.1 above. (Note: Secondary stop code 692 would never be used in this scenario because Vet Centers have no STA -3/Station Number).

B.2.c. Exception 2: VAMC to VAMC Telemental Health

In the rare situation where one VAMC provides another VAMC with tele mental health services, but has operational problems transferring costs on a monthly basis, they can record telemental health care as described in Section B.1 above.

B.2.d. Alpha Codes for Telemental Health

In a six-month experiment, VHA Telemental Health Programs will use a 4-character DSS Alpha Code to designate the facility and provider, at the facility, providing the mental health care via videoteleconference, by combining the nationally assigned 3-digit Station Number with a locally assigned single-letter designator (e.g., Dr. Jane Doe = A, Dr. Joe Smith = B)

Section C. Store-and-Forward Telemedicine

C.1 Teleradiology and Other Diagnostic Studies

C.1.a. CPT Coding of Diagnostic Radiology

X-ray procedures in VHA are described in hundreds of Current Procedural Terminology (CPT) codes that comprise the 70000 CPT Series for x-rays. Currently the CPT code 76140 'Consultation on x-ray exam made elsewhere, written report' is frequently used in VHA to code for teleradiology. The 70000 CPT series requires the use of an associated modifier.

Modifiers that are presently in use include[i]:

Modifier	Description
26	PC Professional Component for radiologist professional service (Image Reading)
27	TC Technical Component for imaging technologist technical service (Image Capturing)

Problematic issues associated with CPT coding for teleradiology in VHA:

1. The use of modifiers is idiosyncratic depending on the site
2. Using the 76140 code obfuscates being able to describe what type of imaging exam is taking place (e.g. x-ray, CT, MRI, US, head, neck, abdo, upper extremity, etc.)

C.1.b. DSS Coding of Diagnostic Studies

For the entire CPT 70000 Series, DSS offers a handful of 'Primary Stop Codes'

Code	Diagnostic Study
105	X-ray (e.g. paired with 703 Secondary Stop Code for Mammogram = 105703)
106	EEG
107	EKG (e.g. paired with 473 Secondary Stop Code for Echocardiogram = 107473)
109	Nuclear Medicine
115	Ultrasound
150	CT
151	MRI

[i] Not all modifiers are available for use in all VHA systems

For capture of store-and forward telemedicine activity the same 690, 692 and 693 Secondary Stop Codes (modifiers) are used as are used for real-time telemedicine.

DSS Modifier	Description
690	Where the patient is
692	Where the provider is, if same station (STA3) as patient
693	Where the provider is, if different station (STA3) as patient

Example DSS Identifier pairings

DSS Modifier	Description
105-690	Originating Site X-ray
105-692	Distant Site (same STA 3) X-ray
151-693	Distant Site (different STA 3) MRI

Anomalies arising with this DSS practice:

1. Radiology software package splits some DSS pairings
2. If VISTA is on separate DHCP databases in the OS and the DS then it is not possible to capture the technical and professional components of diagnostic investigations such as X-rays and workload credit has to be given to either DS or OS site but cannot currently be given to both.

C.2 Store-and-Forward (other than Teleradiology)

C.2.a. CPT Coding for Store-and-Forward (other than Teleradiology)

The GQ modifier must be used to denote the professional component store-and-forward clinic with no billing for services that were provided using an asynchronous telecommunications system. For further information about the use of GQ modifier see the CMS Program Memorandum Transmittal AB-01-69[5].

Modifier	Description
99499	Occasion of Service without patient/family interaction Unlisted evaluation and management service. To be used by privileged providers evaluating and providing advice on pre-recorded telemedicine encounters.
99499GQ	Same as non-count clinic (e.g. teledermatology, teleophthalmology).

C.2.b. DSS Coding for Store-and-Forward (other than Teleradiology)

Examples of DSS Identifier Stopcode pairs

DSS Modifier	Description
304690	Originating Site Teledermatology (Store-and-Forward)
304692	Distant Site (Same STA 3) Teledermatology (Store-and-Forward)
304693	Distant Site (Different STA 3) Teledermatology (Store-and-Forward)

DSS Modifier	Description
407690	Originating Site Teleophthalmology (Store-and-Forward)
407692	Distant Site (Same STA 3) Teleophthalmology (Store-and-Forward)
407693	Distant Site (Different STA 3) Teleophthalmology (Store-and-Forward)

Section D. Care Coordination/Home Telehealth

D.1 Coding for Care Coordination/Home Telehealth services

All details of VHA healthcare, including care coordination and home telehealth activities, must be documented. VHA is standardizing coding for care coordination and home telehealth in order to accurately account for the types of care and services provided through the use of telecommunication devices, from various VHA providers to veterans in their place of residence.

VHA Home Telehealth is always a component of a larger VHA care program or service such as Care Coordination (Please visit www.va.gov/occ for additional information), Spinal Cord Injury, Home Based Primary Care, Geriatrics, Mental Health Intensive Case Management, etc. – and, as you will see in the DSS Coding section that follows, VHA 'bookkeeping' conventions require designated DSS codes to distinguish between specific programs performing very similar home telehealth activities.

All home telehealth 'visits' or monitoring and any clinical progress must be entered in the patient's medical record in accordance with standard VHA medical record documentation procedures, to include being recorded at the parent facility where the provider is physically located. Since remote healthcare delivery into non-healthcare settings is an extension of the VA medical center, medical record documentation must adhere with current VHA and local medical center policies. Because home health codes are time-based, home telehealth documentation must contain beginning and ending times to ensure proper coding.

D.1.a. CPT and HCPCS G-code Coding for CCHT Count Clinics

Examples of CPT codes that may be used for coding care coordination and home telehealth (Note: Corresponding DSS codes used to identify which service care line (i.e., HBPC, Primary Care, MHICM, Cardiac, etc.) to be credited for providing the home telehealth care):

CPT	Description	Typical Use
82962GQ or GT	Glucose blood by monitoring device	Monitoring HgbA1c via glucometer
90804GT	Insight oriented psycho-therapy by licensed practitioner 20-30 minutes	Licensed practitioner performing psychotherapy *LISW cannot use the codes defined with the E&M component
90805GT	Insight oriented psycho-therapy	Licensed practitioner

	by licensed practitioner	performing psychotherapy *LISW cannot use the codes defined with the E&M component
90806GT	Insight oriented psycho-therapy by licensed practitioner 45-50 minutes	Licensed practitioner performing psychotherapy *LISW cannot use the codes defined with the E&M component
90807GT	Insight oriented psycho-therapy by licensed practitioner	Licensed practitioner performing psychotherapy *LISW cannot use the codes defined with the E&M component
90808GT	Insight oriented psycho-therapy by licensed practitioner 75-80 minutes	Licensed practitioner performing psychotherapy *LISW cannot use the codes defined with the E&M component
90809GT	Insight oriented psycho-therapy by licensed practitioner	Licensed practitioner performing psychotherapy *LISW cannot use the codes defined with the E&M component
90862GQ or GT	Medication Management	Monitoring compliance
90862GQ or GT	Evaluation of ongoing psychiatric drug management	Managing and issuing psychiatric drug therapy
97535GT	Self Care/Home Assessment	Ongoing patient assessment
99201GT	New patient video-based home visit (20 min)	Licensed practitioner activity with new patient
99202GT	New patient video-based home visit (30 min)	Licensed practitioner activity with new patient
99203GT	New patient video-based home visit (45 min)	Licensed practitioner activity with new patient
99204GT	New patient video-based home visit (60 min)	Licensed practitioner activity with new patient
99205GT	New patient video-based home visit (75 min)	Licensed practitioner activity with new patient
99211GT	Established patient video-based home visit (5 min)	Licensed practitioner activity with established

		patient
99212GT	Established patient video-based home visit (10 min)	Licensed practitioner activity with established patient
99213GT	Established patient video-based home visit (15 min)	Licensed practitioner activity with established patient
99214GT	Established patient video-based home visit (25 min)	Licensed practitioner activity with established patient
99215GT	Established patient video-based home visit (40 min)	Licensed practitioner activity with established patient
99341GT	New patient home visit (20 min)	
99342GT	New patient home visit (30 min)	
99343GT	New patient home visit (45 min)	
99344GT	New patient home visit (60 min)	
99345GT	New patient home visit (75 min)	
99347GT	Established patient home visit (15 min)	
99348GT	Established patient home visit (25 min)	
99349GT	Established patient home visit (40 min)	
99350GT	Established patient home visit (60 min)	
99371	Telephone call	Reporting results of test, advising, or discussing any issue
99372	Telephone call	Reporting results of test, advising, or discussing any issue
99373	Telephone call	Reporting results of test, advising, or discussing any issue

List of HCPCS G-codes that may be used for coding care coordination and home telehealth:

G-code	Home Health Setting Service Description
G0151	Physical Therapist Services, each 15 minutes
G0152	Occupation Therapist Services, each 15 minutes
G0153	Speech and Language Pathologist Services, each 15 minutes
G0154	Skilled Nurse Services, each 15 minutes

G0155	Clinical Social Worker Services, each 15 minutes
G0156	Home Health Aide Services, each 15 minutes

D.1.b. DSS Coding for Care Coordination/Home Telehealth Count Clinics

DSS coding for home telehealth differs from other telehealth coding due to VHA 'bookkeeping' conventions established to document workload credit for whichever VHA program or group (e.g. Care Coordination, Primary Care, HBPC, Geriatrics, SCI, Cardiology, Mental Health Intensive Case Management, et al.) is doing the work to provide the service.

The 'bookkeeping' for all VHA home telehealth activity is accomplished by using (at least) one of the seven DSS Home Telehealth/Care Coordination codes defined in Appendix 19. Illustrative examples of use of these codes by various VHA services are given below.

NOTE 1: As with other DSS codes restricted to specific services, the use of three of the seven DSS Home Telehealth/Care Coordination codes in Appendix 19 is reserved for VHA Care Coordination programs with designated Care Coordination staffing. Whereas VHA Care Coordination programs operating with staff designated to other services (e.g., HBPC, Geriatrics, Cardiology, SCI, etc.) should use the service-specific DSS codes in combination with the five Care Coordination/Home Telehealth codes listed in Appendix 19.

NOTE 2: Because Care Coordination is more than Home Telehealth, VHA Care Coordination programs should use the appropriate existing DSS codes (other than Appendix 19) to document care coordination activity other than home telehealth.

DSS Stop Codes

For use by all VHA groups conducting care coordination/home telehealth

Primary 371: Use Primary Stop Code 371 to indicate that the VAMC or CBOC clinical staff conducted an initial assessment of the patient in the VHA facility for inclusion in the CCHT program, no Credit Pair needed/used . **MAS Count**.

Examples using 371 Primary Stop Code:

DSS Code	Description
371	VHA clinical staff conducted an initial assessment, in the VHA facility, of the patient for inclusion in the CCHT program

Secondary 179: Real Time Videoconferencing

Use Secondary Stop Code (Credit Pair) 179 when recording workload by VA health care professionals **using real-time videoconferencing as a means to replicate aspects of face-to-face assessment and care delivery** to

patients IN THEIR HOMES using telehealth. This assessment and care may include: health/social evaluations, wound management, exercise plans, patient appearance, monitoring patient self-care, medication management, monitoring vital signs, including pain. These telehealth encounters must be electronically documented in CPRS. Fully meeting criteria for provider encounter. Use provider work-unit related stop as primary. **MAS Count. Secondary Stopcode use only.** (See Appendix 15. for guidance)

Examples using 179 (Credit Pair) Secondary Stop Code:

DSS Code	Description
171179	HBPC Nurse care/services via real-time interactive video (Telemonitor or video telephone)
318179	Geriatric staff care /services via real-time interactive video (Telemonitor or video telephone)
685179	Care Coordination Staff care/services via real-time interactive video (Telemonitor or video telephone)
552179	MHICM staff care/services via real-time interactive video (Telemonitor or video telephone)

Notes:

1. The DSS 179 Credit Pair must only be used when its use can be substantiated by the requisite documentation.
2. The DSS 179 Credit Pair must never be used with any 'telephone' Primary Codes (e.g., 178, 686, 324, etc.)
3. The DSS 179 Credit Pair must never be used with "Home Visit' Primary Code 118.
4. The DSS 179 Credit Pair must never be used when the simple videophone call is clinically equivalent to a standard (audio only) telephone call. CPT codes 99371-99373 must be used instead

Secondary 371: Initial assessment of patient or technology set up.
Use Secondary Stop Code (Credit Pair) 371 for recording Initial evaluation or assessment of patient to be enrolled in a VHA Care Coordination Home Telehealth (CCHT) program.

Examples using 371 (Credit Pair) Secondary Stop Code:

DSS Code	Description
118371	Home visit to perform patient's initial assessment, evaluation for enrollment in CCHT and/or CCHT technology installation.
171371	HPBC Nurse performs patient's initial assessment, evaluation for enrollment in CCHT and/or CCHT technology installation.
685371	Office visit – Care Coordination staff performs patient's initial assessment or evaluation in the office.
318371	Office visit – Geriatric staff performs patient's initial assessment or evaluation in the office.

Secondary 684: **Non-Video Intervention**

Use Secondary Stop Code (Credit Pair) 684 for recording intervention resulting from a clinical change in the patient's condition revealed via HOME TELEHEALTH NON-VIDEO MONITOR (see DSS Primary Code 683 below) necessitating contact with the provider for resolution. This intervention constitutes a clinical encounter and must be electronically docu mented in CPRS. Assessment and care include: vital signs, self-care, pain management, wound management, medication management, health/social assessment, etc. VA Medical Centers providing this care will have made significant investment in the staffing and technological infrastructure required to support such complex care provision in the home environment. **MAS Count. Secondary Stopcode use only.** (See Appendix 12. for guidance.)

Examples using 684 (Credit Pair) Secondary Stop Code:

DSS Code	Description
118684	Home visit for intervention with patient, due to alert received via home telehealth non-video monitoring.
685684	Care Coordination Staff intervention with patient (patient travels to office) due to alert received via home telehealth non-video monitoring
686684	Care Coordination Staff telephone call intervention with patient at the office due to alert received via home telehealth non-video monitoring
178684	HBPC Nurse telephone call intervention with patient due to alert received via home telehealth non-video monitoring
171684	HBPC Nurse intervention with patient due to alert received via home telehealth non-video monitoring

DSS Stop Codes
Restricted use: only for VHA Care Coordination Program Staff

Secondary 685 (Care Coordination Program Only): Use Secondary Stop Code (Credit Pair) 685 to indicate that any activity/care (specified in the Primary Code) was performed/provided by VHA Care Coordination staff. **MAS Count.**

Examples using 685 (Credit Pair) Secondary Stop Code:

DSS Code	Description
118685	Home visit by Care Coordination clinical staff
121685	Residential Care (non-Mental Hlth) by Care Coordination clinical staff
503685	Mental Hlth Residential Care for an Individual by Care Coordination clinical staff

Primary 685 (Care Coordination Program Only): Use Primary Stop Code 685 to identify Care Coordination clinic where activity was performed. **MAS Count.** (Applicable to Option 1 only)

Examples using 685 Primary Stop Code:

DSS Code	Description
685	Office Visit (Medical Center/Clinic walk-in) Care Coordination Staff intervention NOT due to alert via home telehealth non-video monitoring
685179	Care Coordination Clinic care/services via real-time interactive video (Telemonitor or video telephone)
685684	Care Coordination Clinic care/services intervention due to alert via home telehealth non-video monitoring

Primary 686 (Care Coordination Program Only): Use Primary Stop Code 686 to indicate that the Care Coordination clinical staff contacted patient via telephone without any home telehealth activity/care performed, no Credit Pair needed/used. **MAS Count**. Other VHA service unit staff would use assigned telephone contact (e.g. 178-HBPC; 324-Medicine; 326-Geriatrics) with 685 as secondary to indicate Care Coordination aspect of telephone contact.

Examples using 686 Primary Stop Code:

DSS Code	Description
686	Care Coordination clinical staff contacted patient via telephone

D.1.c. CPT Coding for Non-Count Clinics

Remote Daily Monitoring of Patients: The receipt of health care information (e.g., vital signs) via electronic monitoring devices implemented in the home (e.g., Health Buddy) does not independently constitute an encounter. The services of review, interpretation and associated documentation by a VA health care provider should be recorded as an administrative intervention. This type of encounter would be associated with a non-count clinic.

Code	Description	Typical Use
99090GQ or GT	Analysis of information data stored in computers	Non-video monitoring of patient health through use of in-home messaging and measuring device
V71.89	Observation for other specified Condition	Diagnosis entered into the problem list to indicate the

		patient enrolled in CCHT program
V71.9	Observation for unspecified Condition	Diagnosis entered into the problem list to indicate the patient enrolled in CCHT program

D.1.d. DSS Coding for Non-Count Clinics

674 Primary – Use Primary Stop Code 674 when recording MAS non-count workload by VA health care professionals providing home telehealth patient orientation and technology installation/education without provision of any medical assessment or intervention.

Example of when to use 674 Primary Stop Code:

DSS Code	Description
674	VA health care professionals providing home telehealth patient orientation and technology installation/education without provision of any medical assessment or intervention; Non-count MAS; count DSS

683 Primary – Use Primary Stop Code 683 when recording MAS non-count workload by VA health care professionals **using non-video electronic in-home monitoring devices** for the remote monitoring of patients on a regular basis and interpretation of patient's health care information received through electronic transmission as a means to replicate aspects of face-to-face assessment and care delivery to patients IN THEIR HOMES using telehealth. (See Appendix 13. for step-by-step guidance)

Example of when to use 683 Primary Stop Code:

DSS Code	Description
683	Program reviews/monitors non-video home telehealth; Non-count MAS; count DSS

Alternatives to code this workload:

1: Most VHA staff use Event Capture System (ECS) products in conjunction with the 683 Primary Stop Code for DSS and do (weekly spreadsheet upload) batch entry or on ECS (weekly manual) batch entry.

2: 683 may be considered 'DSS count' using the Clinic Stopcode Worksheet, and workload may be indicated using the CLI feeder key/product.

Reviewing/monitoring non-video home telehealth workload collection should be entered weekly, per patient SSN, as a 10-minute product per week.

Event Capture System Coding for non-count non-video home telehealth monitoring
In addition to the use of the 683 Primary Stop Code, a corresponding ECS code is required to describe which type of patient care is being delivered.

ECS Code	Description
TM001	Care Coordination Cardiac Disease CD patient non-video review/monitor home telehealth; Non-count MAS; count DSS
TM002	Care Coordination Coagulation management CG patient non-video review/monitor home telehealth; Non-count MAS; count DSS
TM003	Care Coordination Dementia DE patient non-video review/monitor home telehealth; Non-count MAS; count DSS
TM004	Care Coordination Diabetes Mellitus DM patient non-video review/monitor home telehealth; Non-count MAS; count DSS
TM005	Care Coordination Hypertension HT patient non-video review/monitor home telehealth; Non-count MAS; count DSS
TM006	Care Coordination Infectious Disease ID patient non-video review/monitor home telehealth; Non-count MAS; count DSS
TM007	Care Coordination Mental Health MH patient non-video review/monitor home telehealth; Non-count MAS; count DSS
TM008	Care Coordination Palliative Care PL patient non-video review/monitor home telehealth; Non-count MAS; count DSS
TM009	Care Coordination Pain Management PN patient non-video review/monitor home telehealth; Non-count MAS; count DSS
TM010	Care Coordination Pulmonary Disease PD patient non-video review/monitor home telehealth; Non-count MAS; count DSS
TM011	Care Coordination Rehabilitation RH patient non-video review/monitor home telehealth; Non-count MAS; count DSS
TM012	Care Coordination Spinal Cord Injury SC patient non-video review/monitor home telehealth; Non-count MAS; count DSS
TM013	Care Coordination Wound Care WC patient non-video review/monitor home telehealth; Non-count MAS; count DSS
TM014	Care Coordination Multiple Co-morbidities MM patient non-video review/monitor home telehealth; Non-count MAS; count DSS

D.1.e. Alpha Coding for VHA Care Coordination Roll Out
To capture Care Coordination workload appropriately among the Networks complying with "Conditions of Participation" of Care Coordination / Home Telehealth, there are a series of Alpha Codes available on DSS. (See Appendix 20. for current list of Care Coordination Alpha Codes.) These Alpha Codes are assigned to such programs by the VHA Office of Care Coordination.

These are additional identifiers (14 new codes) for DSS clinic feederkeys provided so that each type of CCHT activity can be identified through DSS whenever a CCHT stop code service is used. These 14 alpha codes for each type of CCHT activity area can also be set-up to show the specific provider type if that is desired for internal tracking purposes and differential costing and productivity studies.

Examples of Alpha Codes usages

DSS Code	Description
118371CDRN	Care Coordination staff Registered Nurse (RN) performs initial assessment/evaluation/set-up, for home telehealth, in Cardiac Disease (CD) patient's place of residence
685684PDNP	Care Coordination staff Nurse Practitioner (NP) intervenes due to alert via non-video monitoring home telehealth of Pulmonary Disease (PD) patient
121685PLNP	Care Coordination staff Nurse Practitioner (NP) performs residential visit of Palliative Care (PL) patient
685179MHSW	Care Coordination staff Social Worker (SW) performs care services via real-time interactive video (Telemonitor or video telephone) for Mental Health (MH) patient
686WCMD	Care Coordination staff Medical Doctor (MD) performs a telephone call to Wound Care (WC) patient
170684CDMD	HBPC staff Doctor (MD) intervention (Doc goes out, or patient comes in) due to alert from non-video home Telehealth monitoring of patient with Cardiac Disease (CD), all as part of VISN Care Coordination program

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APPENDIX 1

Originating Site Coding/Billing Instruction Summary for Real-Time Telemedicine
*** Except Ongoing Telemental Health**

Originating Site Documentation Process for Reimbursement and DSS Workload Credit		
	Action	**Description**
1	Establish count clinic	OS (either VAMC or CBOC) establishes clinic including setting up encounter form in VISTA
2	Enter consult into DS CPRS and load OS patient in DS VISTA (with Inter-Facility Consult where available)	OS and DS IFC teams set up IFC to automatically enter consult into DS CPRS and load OS patient in DS VISTA, or auto-alerts trouble. If no IFC, OS and DS Telemed Coordinators load patients.
3	Register patient	OS MAS registers patient into OS and (if access) DS system, coords w/ DS Tmed Coordinator
4	Present patient to DS provider	OS provider (or designee) presents patient to Distant Site provider
5	Document encounter	Where available, IFC auto-alerts OS that DS consult is complete and DS report (including DS provider identification) available for view in OS CPRS (If no IFC, OS completes encounter form in CPRS) and checks patient out in Appointment Management for workload/reimbursement purposes
5a	- Update patient record	OS enters progress notes in CPRS
5b	- Record code for facility fee	OS always enters Q3014 for presenting facility fee, as well as additional HCPCS codes for additional services provided
5c	- Record code for billing	OS enters appropriate CPT and ICD-9 codes in VISTA
5d	- Record code for workload credit	OS enters DSS identifier 690 as Secondary stopcode (aka credit pair)
6	Bill for telemedicine count clinic	OS bills (1st and 3rd party) for telemedicine count clinic
6a	- If OS=PPS, Bill 1st party for co-pay	OS designated as Prospective Payment System (PPS) site bills 1st party for co-pay
6b	- If OS=PPS, Bill 3rd party for facility	OS designated as Prospective Payment System (PPS) site bills 3rd party for facility fee
7	Document (same day) encounters	OS completes patient encounter form for multiple visits on one day by one patient

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APPENDIX 2

Distant Site (Same STA 3(Station Number)) Coding/Billing Instruction Summary for Real-Time Telemedicine
***Except Ongoing Telemental Health**

Distant Site (Same STA 3) Documentation Process for Reimbursement and DSS Workload Credit		
	Action	**Description**
1	Establish count clinic	DS (either VAMC or CBOC) establishes clinic including setting up encounter form in VISTA
2	Enter consult into DS CPRS and load OS patient in DS VISTA (with Inter-Facility Consult where available)	DS and OS IFC teams set up IFC to automatically load OS patient in DS VISTA, or auto-alerts trouble. If no IFC, OS and DS Telemed Coordinators load patients.
3	Register patient	DS Med Admin Service (or IT staff) accesses OS VISTA list of scheduled patients and schedules same list in DS VISTA. DS Telemed Coordinator liaises with OS Telemedicine Coordinator
4	Provide consult or care for OS patient	DS provides consult or care to patient, presenter and or provider at OS
5	Document telemedicine count clinic	DS completes patient encounter form in CPRS. Where available, IFC auto-alerts OS that consult is complete and report (including DS provider identification) available for view in OS CPRS and checks patient out in Appointment Management for workload/reimburs purposes
5a	- Update patient record	OS enters progress note in CPRS for regular consult; OS and DS enter progress notes for follow-up consults
5b	- Record code for billing	OS Enters CPT and ICD-9 codes in VISTA, DS adds CPT and ICD-9 codes and appropriate CPT modifier GT (for Real Time Telemedicine – professional component) to CPT
5c	- Record for workload credit	DS pairs 692 Secondary stopcode (aka credit pair) with Primary stopcode appropriate to clinic
6	Bill for telemedicine count clinic	DS bills (3rd party only) for telemedicine count clinic
6a	- Never Bill 1st party co-pay	OS bills 1st party co-pay (and only then if OS is the PPS)
6b	- If DS=PPS, Bill 3rd party for professional fee	DS designated as Prospective Payment System (PPS) site bills 3rd party for professional fee
7	Document any additional (same patient same day) encounters	DS completes patient encounter form for multiple visits on one day by one patient

APPENDIX 3

Distant Site (Different STA 3 (Station Number)) Coding/Billing Instruction Summary for Real -Time Telemedicine
***Except Ongoing Telemental Health**

Distant Site (Different STA 3) Documentation Process for Reimbursement and DSS Workload Credit		
	Action	**Description**
1	Establish count clinic	DS (either VAMC or CBOC) establishes clinic including setting up encounter form in VISTA
2	Enter consult into DS CPRS and load OS patient in DS VISTA (with Inter-Facility Consult where available)	DS and OS IFC teams set up IFC to automatically load OS patient in DS VISTA, or auto-alerts trouble. If no IFC, OS and DS Telemed Coordinators load patients.
3	Register patient	If OS unable to access DS system, DS Med Admin Service (or IT staff) registers patient into DS system. DS coordinates with OS Telemedicine Coordinator
4	Provide consult or care for OS patient	DS provides consult or care to patient, presenter and or provider at OS
5	Document telemedicine count clinic	DS completes patient encounter form in CPRS. Where available, IFC auto -alerts OS that consult is complete and report (including DS provider identification) available for view in OS CPRS and checks patient out in Appointment Management for workload/reimbursement purposes
5a	- Update patient record	OS enters progress note in CPRS for regular consult; OS and DS enter progress notes for follow-up consults
5b	- Record code for billing	OS? Enters CPT and ICD-9 codes in VISTA, DS adds CPT and ICD-9 codes and appropriate CPT modifier GT (for Real Time Telemedicine – professional component) to CPT
5c	- Record for workload credit	DS pairs 693 Secondary stopcode (aka credit pair) with Primary stopcode appropriate to clinic
6	Bill for telemedicine count clinic	DS bills (3rd party only) for telemedicine count clinic
6a	- Never Bill 1st party co-pay	OS bills 1st party co-pay (and only then if OS is the PPS)
6b	- If DS=PPS, Bill 3rd party for professional fee	DS designated as Prospective Payment System (PPS) site bills 3rd party for professional fee
7	Document any additional (same patient same day) encounters	DS completes patient encounter form for multiple visits on one day by one patient

APPENDIX 4

Originating Site Coding/Billing Instruction Summary for Ongoing Real-time Telemental Health Care Between VAMC and CBOC

Originating Site Documentation Process (mainly performed by DS provider) for Reimbursement and DSS Workload Credit		
	Action	**Description**
1	Establish count clinic	DS (either VAMC or CBOC) establishes/schedules clinic in OS including setting up encounter form in VISTA using either DSS pair 502690 (when no co-therapist present at OS) or 502692 (when co-therapist present at OS.) If present at OS, the OS co-therapist establishes their own clinic using DSS pair 502690 at OS and records their work at OS.
2	Enter consult into OS CPRS and load OS patient in OS VISTA (with Inter-Facility Consult if available)	OS and DS IFC teams set up IFC to automatically enter consult into OS CPRS and load OS patient in OS VISTA, or auto-alerts trouble. If no IFC, OS/DS telemed coordntrs collaborate to load patient into OS system.
3	Register patient	OS MAS registers patient into OS system
4	Present patient to DS provider	OS provider (or designee) presents patient to Distant Site provider
5	Document encounter	Where available, IFC auto-alerts OS that DS telemental health care session is complete and DS report (including DS provider identification) is available for view in OS CPRS (If no IFC, OS completes encounter form in CPRS) and checks patient out in Appointment Management for workload/reimbursement purposes
5a	- Update patient record	DS enters progress notes in OS CPRS
5b	- Record code for facility fee	DS always enters Q3014 to credit OS for facility fee, as well as add'l HCPCS codes for add'l care
5c	- Record code for billing	DS enters appropriate CPT and ICD-9 codes in VISTA
5d	- Record code for workload credit	DS enters either DSS identifier 690 as Secondary Stop Code (aka credit pair) when no co-therapist present at OS, or 692 when co-therapist is at OS. If co-therapist is at OS, OS enters DSS identifier 690 as Secondary. Use Alpha code (Provider Station Number plus MD identifier)
6	Bill for telemedicine count clinic	DS bills (1st and 3rd party) for telemedicine count clinic
6a	If OS=PPS, Bill 1st party for co-pay	OS designated as Prospective Payment System (PPS) site bills 1st party for co-pay
6b	If OS=PPS, Bill 3rd party for facility	OS designated as Prospective Payment System (PPS) site bills 3rd party for facility fee
6c	If DS=PPS, Bill 3rd party for professional fee	DS Medical Care Collection Fund bills 3rd party for professional fee
7	Document (same day) encounters	DS completes OS CPRS patient encounter form for multiple visits on one day by one patient

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APPENDIX 5

Originating Site Coding/Billing Instruction Summary for Ongoing Real-time Telemental Health Between Two VAMC's

Originating Site Documentation Process for Reimbursement and DSS Workload Credit		
	Action	**Description**
1	Establish count clinic	OS VAMC establishes clinic including setting up encounter form in VISTA
2	Enter consult into DS CPRS and load OS patient in DS VISTA (with Inter-Facility Consult where available)	OS and DS IFC teams set up IFC to automatically enter consult into DS CPRS and load OS patient in DS VISTA, or auto-alerts trouble. If no IFC, OS and DS Telemed Coordinators load patients.
3	Register patient	OS MAS registers patient into OS and (if access) DS system, cords w/ DS Tmed Coordinator
4	Present patient to DS provider	OS provider (or designee) presents patient to Distant Site provider
5	Document encounter	Where available, IFC auto-alerts OS that DS consult is complete and DS report (including DS provider identification) available for view in OS CPRS (If no IFC, OS completes encounter form in CPRS) and checks patient out in Appointment Management for workload/reimbursement purposes
5a	- Update patient record	OS enters progress notes in CPRS
5b	- Record code for facility fee	OS always enters Q3014 for presenting facility fee, as well as additional HCPCS codes for any additional services provided
5c	- Record code for billing	OS enters appropriate CPT and ICD-9 codes in VISTA
5d	- Record code for workload credit	OS enters DSS identifier 690 as Secondary stopcode (aka credit pair)
6	Bill for telemedicine count clinic	OS bills (1st and 3rd party) for telemedicine count clinic
6a	- If OS=PPS, Bill 1st party for co-pay	OS designated as Prospective Payment System (PPS) site bills 1st party for co-pay
6b	- If OS=PPS, Bill 3rd party for facility	OS designated as Prospective Payment System (PPS) site bills 3rd party for facility fee
7	Document (same day) encounters	OS completes patient encounter form for multiple visits on one day by one patient

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APPENDIX 6

Distant Site (SAME STA 3(Station Number)) Coding/Billing Instruction Summary for Ongoing Real -time Telemental Health Between Two VAMC's

Distant Site (Same STA 3) Documentation Process for Reimbursement and DSS Workload Credit		
	Action	**Description**
1	Establish count clinic	DS VAMC establishes clinic including setting up encounter form in VISTA
2	Enter consult into DS CPRS and load OS patient in DS VISTA (with Inter-Facility Consult where available)	DS and OS IFC teams set up IFC to automatically load OS patient in DS VISTA, or auto-alerts trouble. If no IFC, OS and DS Telemed Coordinators load patients.
3	Register patient	DS Med Admin Service (or IT staff) accesses OS VISTA list of scheduled patients and schedules same list in DS VISTA. DS Telemed Coordinator liaises with OS Telemedicine Coordinator
4	Provide consult or care for OS patient	DS provides consult or care to patient, presenter and or provider at OS
5	Document telemedicine count clinic	DS completes patient encounter form in CPRS. Where available, IFC auto-alerts OS that consult is complete and report (including DS provider identification) available for view in OS CPRS and checks patient out in Appointment Management for workload/reimburs purposes
5a	- Update patient record	OS enters progress note in CPRS for regular consult; OS and DS enter progress notes for follow-up consults
5b	- Record code for billing	OS Enters CPT and ICD-9 codes in VISTA, DS adds CPT and ICD-9 codes and appropriate CPT modifier GT (for Real Time Telemedicine – professional component) to CPT
5c	- Record for workload credit	DS pairs 692 Secondary stopcode (aka credit pair) with Primary stopcode appropriate to clinic
6	Bill for telemedicine count clinic	DS bills (3rd party only) for telemedicine count clinic
6a	- Never Bill 1st party co-pay	OS bills 1st party co-pay (and only then if OS is the PPS)
6b	- If DS=PPS, Bill 3rd party for professional fee	DS designated as Prospective Payment System (PPS) site bills 3rd party for professional fee
7	Document any additional (same patient same day) encounters	DS completes patient encounter form for multiple visits on one day by one patient

APPENDIX 7

Distant Site (DIFFERENT STA 3 (Station Number)) Coding/Billing Instruction Summary for Ongoing Real-time Telemental Health Between Two VAMC's

Distant Site (Different STA 3) Documentation Process for Reimbursement and DSS Workload Credit		
	Action	**Description**
1	Establish count clinic	DS VAMC establishes clinic including setting up encounter form in VISTA
2	Enter consult into DS CPRS and load OS patient in DS VISTA (with Inter-Facility Consult where available)	DS and OS IFC teams set up IFC to automatically load OS patient in DS VISTA, or auto-alerts trouble. If no IFC, OS and DS Telemed Coordinators load patients.
3	Register patient	If OS unable to access DS system, DS Med Admin Service (or IT staff) registers patient into DS system. DS coordinates with OS Telemedicine Coordinator
4	Provide consult or care for OS patient	DS provides consult or care to patient, presenter and or provider at OS
5	Document telemedicine count clinic	DS completes patient encounter form in CPRS. Where available, IFC auto-alerts OS that consult is complete and report (including DS provider identification) available for view in OS CPRS and checks patient out in Appointment Management for workload/reimbursement purposes
5a	- Update patient record	OS enters progress note in CPRS for regular consult; OS and DS enter progress notes for follow-up consults
5b	- Record code for billing	OS Enters CPT and ICD-9 codes in VISTA, DS adds CPT and ICD-9 codes and appropriate CPT modifier GT (for Real Time Telemedicine – professional component) to CPT
5c	- Record for workload credit	DS pairs 693 Secondary stopcode (aka credit pair) with Primary stopcode appropriate to clinic
6	Bill for telemedicine count clinic	DS bills (3rd party only) for telemedicine count clinic
6a	- Never Bill 1st party co-pay	OS bills 1st party co-pay (and only then if OS is the PPS)
6b	- If DS=PPS, Bill 3rd party for professional fee	DS designated as Prospective Payment System (PPS) site bills 3rd party for professional fee
7	Document any additional (same patient same day) encounters	DS completes patient encounter form for multiple visits on one day by one patient

APPENDIX 8

Distant Site Coding/Billing Instruction Summary for Ongoing Real-time Telemental Health Between VAMC and Vet Center

Distant Site Documentation Process for Reimbursement and DSS Workload Credit		
	Action	**Description**
1	Establish count clinic	DS establishes clinic including setting up encounter form in VISTA
2	Enter consult into DS CPRS and load home telehealth patient in DS VISTA	DS automatically loads patient data in DS VISTA.
3	Register patient	DS Med Admin Service (or IT staff) accesses list of scheduled patients and schedules same list in DS VISTA.
4	Provide consult or care for home telehealth patient	DS provides consult or care to patient or provider with patient at Vet Center
5	Document telemedicine count clinic	DS completes patient encounter form in CPRS and checks patient out in Appointment Management for workload/reimbursement purposes
5a	- Update patient record	DS enters progress note in CPRS for regular consult or follow-up consults
5b	- Record code for billing	DS enters CPT and ICD-9 codes in VISTA, DS adds CPT and ICD-9 codes and appropriate CPT modifier GT (for Real Time Telemedicine – professional component) to CPT
5c	- Record for workload credit	DS pairs DSS Secondary stopcode (a.k.a. credit pair) 179 with Primary stopcode 502(?) or other Primary stopcode appropriate to clinic
6	Bill for telemedicine count clinic	DS bills (3rd party only) for telemedicine count clinic
6a	- Never Bill 1st party co-pay	DS never bills 1st party co-pay
7	Document any additional (same patient same day) encounters	DS completes patient encounter form for multiple visits on one day by one patient

APPENDIX 9

Originating Site Coding/Billing Instruction Summary for Teleradiology Store & Forward

Originating Site Documentation Process for Reimbursement and DSS Workload Credit		
	Action	**Description**
1	Establish count clinic	OS (either VAMC or CBOC) establishes clinic including setting up encounter form in VISTA
2	Enter consult into DS CPRS and load OS patient in DS VISTA (with Inter-Facility Consult where available)	DS and OS IFC teams set up IFC to automatically load OS patient in DS VISTA, or auto-alerts trouble. If no IFC, OS and DS Telemed Coordinators coordinate loading patient data.
3	Register patient	OS MAS registers patient into OS and (if access) DS system. OS coordinates with DS Telemedicine Coordinator
4	Capture patient image or data and forward to DS provider	OS technologist or other staff captures and records image or data and transmits to provider at distant site for review and report
5	Document telemedicine count clinic	Where available, IFC auto-alerts OS that DS provider consult is complete and DS provider report (to include DS provider identification) is available for view in OS CPRS. (If no IFC, OS completes patient encounter form in CPRS) and checks patient out in Appointment Management for workload purposes
5a	- Update patient record	OS enters progress note in CPRS for regular consult; OS and DS enter progress notes for follow-up consults
5b	- Do not record code Q3014 for facility fee	Unlike real-time telemedicine, there is (currently) no billing or reimbursement for Store & Forward Telemedicine. OS enters appropriate CPT code with TC modifier for technical component and ICD-9 code
5c	Record for workload credit	OS pairs the DSS 690 Secondary stopcode (aka credit pair) with Primary stopcode appropriate to clinic (e.g., dermatology = 304, ophthalmology = 407)
6	Bill for count clinic	No one bills for telemedicine non-count clinic
6a	- Bill 1st party co-pay	OS does not bill 1st party co-pay
6b	- Bill 3rd party for facility fee	OS bills 3rd party for facility fee
7	Document any additional (same patient same day) encounters	DS completes patient encounter form for multiple visits on one day by one patient

APPENDIX 10

Distant Site (Same STA 3 (Station Number)) Coding/Billing Instruction Summary for Teleradiology Store & Forward

Distant Site (Different STA 3) Documentation Process for Reimbursement and DSS Workload Credit		
	Action	**Description**
1	Establish count clinic	DS (either VAMC or CBOC) establishes clinic including setting up encounter form in VISTA
2	Enter consult into DS CPRS and load OS patient in DS VISTA (with Inter-Facility Consult where available)	DS and OS IFC teams set up IFC to automatically load OS patient in DS VISTA, or auto-alerts trouble. If no IFC, OS and DS Telemed Coordinators coordinate loading patient data.
3	Register patient	If OS unable to access DS system, DS Med Admin Service (or IT staff) registers patient into DS system. DS coordinates with OS Telemedicine Coordinator
4	Provide consult or care for OS patient	DS provides consult or care to patient, presenter and or provider at OS
5	Document telemedicine count clinic	DS completes patient encounter form in CPRS. Where available, IFC auto-alerts OS that consult is complete and report (including DS provider identification) available for view in OS CPRS and checks patient out in Appointment Management for workload/reimbursement purposes
5a	- Update patient record	OS enters progress note in CPRS for regular consult; OS and DS enter progress notes for follow-up consults
5b	- Record code for billing	DS adds appropriate ICD-9 code and CPT code with modifer 26 for professional component
5c	- Record for workload credit	DS pairs 693 Secondary stopcode (aka credit pair) with Primary stopcode appropriate to clinic
6	Bill for telemedicine count clinic	DS bills (3rd party only) for telemedicine non-count clinic
6a	- Do not bill 1st party co-pay	OS does not bill 1st party co-pay
6b	- Bill 3rd party for professional fee	DS bills 3rd party for professional fee
7	Document any additional (same patient same day) encounters	DS completes patient encounter form for multiple visits on one day by one patient

APPENDIX 11

Distant Site (Different STA 3 (Station Number)) Coding/Billing Instruction Summary for Teleradiology Store & Forward

Distant Site (Different STA 3) Documentation Process for Reimbursement and DSS Workload Credit		
	Action	**Description**
1	Establish count clinic	DS (either VAMC or CBOC) establishes clinic including setting up encounter form in VISTA
2	Enter consult into DS CPRS and load OS patient in DS VISTA (with Inter-Facility Consult where available)	DS and OS IFC teams set up IFC to automatically load OS patient in DS VISTA, or auto-alerts trouble. If no IFC, OS and DS Telemed Coordinators load patients.
3	Register patient	If OS unable to access DS system, DS Med Admin Service (or IT staff) registers patient into DS system. DS coordinates with OS Telemedicine Coordinator
4	Provide consult or care for OS patient	DS provides consult or care to patient, presenter and or provider at OS
5	Document telemedicine count clinic	DS completes patient encounter form in CPRS. Where available, IFC auto-alerts OS that consult is complete and report (including DS provider identification) available for view in OS CPRS and checks patient out in Appointment Management for workload/reimbursement purposes
5a	- Update patient record	OS enters progress note in CPRS for regular consult; OS and DS enter progress notes for follow-up consults
5b	- Record code for billing	DS adds appropriate ICD-9 code and CPT code with modifer 26 for professional component
5c	- Record for workload credit	DS pairs 693 Secondary stopcode (aka credit pair) with Primary stopcode appropriate to clinic
6	Bill for telemedicine count clinic	DS does bill (3rd party only) for telemedicine
6a	- Bill 1st party co-pay	OS does bill 1st party co-pay
6b	- Bill 3rd party for professional fee	DS does bill 3rd party for professional fee
7	Document any additional (same patient same day) encounters	DS completes patient encounter form for multiple visits on one day by one patient

APPENDIX 12

Originating Site Coding/Billing Instruction Summary for Store & Forward Other than Radiology Telemedicine

Originating Site Documentation Process for Reimbursement and DSS Workload Credit		
	Action	**Description**
1	Establish non-count clinic	OS (either VAMC or CBOC) establishes clinic including setting up encounter form in VISTA
2	Enter consult into DS CPRS and load OS patient in DS VISTA (with Inter-Facility Consult where available)	DS and OS IFC teams set up IFC to automatically load OS patient in DS VISTA, or auto-alerts trouble. If no IFC, OS and DS Telemed Coordinators coordinate loading patient data.
3	Register patient	OS MAS registers patient into OS and (if access) DS system. OS coordinates with DS Telemedicine Coordinator
4	Capture patient image or data and forward to DS provider	OS technologist or other staff records image or data and transmits to provider at distant site for review and report
5	Document telemedicine non-count clinic	Where available, IFC auto-alerts OS that DS provider consult is complete and DS provider report (to include DS provider identification) is available for view in OS CPRS. (If no IFC, OS completes patient encounter form in CPRS) and checks patient out in Appointment Management for workload purposes
5a	- Update patient record	OS enters progress note in CPRS for regular consult; OS and DS enter progress notes for follow-up consults
5b	- Do not record code Q3014 for facility fee	Unlike real-time telemedicine, there is (currently) no billing or reimbursement for Store & Forward Telemedicine. OS enters CPT 99499 and appropriate ICD-9 code
5c	Record for workload credit	OS pairs the DSS 690 Secondary stopcode (aka credit pair) with Primary stopcode appropriate to clinic (e.g., dermatology = 304, ophthalmology = 407)
6	Never bill for non-count clinic	No one bills for telemedicine non-count clinic
6a	- Never bill 1st party co-pay	Unlike real-time telemedicine, OS does not bill 1st party co-pay
6b	- Never bill 3rd party for facility fee	Unlike real-time telemedicine, OS does not bill 3rd party for facility fee
7	Document any additional (same patient same day) encounters	DS completes patient encounter form for multiple visits on one day by one patient

APPENDIX 13

Distant Site (Same STA 3 (Station Number)) Coding/Billing Instruction Summary for Store & Forward Other than Radiology Telemedicine

Distant Site (Different STA 3) Documentation Process for Reimbursement and DSS Workload Credit		
	Action	**Description**
1	Establish non-count clinic	DS (either VAMC or CBOC) establishes clinic including setting up encounter form in VISTA
2	Enter consult into DS CPRS and load OS patient in DS VISTA (with Inter-Facility Consult where available)	DS and OS IFC teams set up IFC to automatically load OS patient in DS VISTA, or auto-alerts trouble. If no IFC, OS and DS Telemed Coordinators coordinate loading patient data.
3	Register patient	If OS unable to access DS system, DS Med Admin Service (or IT staff) registers patient into DS system. DS coordinates with OS Telemedicine Coordinator
4	Provide consult or care for OS patient	DS provides consult or care to patient, presenter and or provider at OS
5	Document telemedicine non-count clinic	DS completes patient encounter form in CPRS. Where available, IFC auto-alerts OS that consult is complete and report (including DS provider identification) available for view in OS CPRS and checks patient out in Appointment Management for workload/reimbursement purposes
5a	- Update patient record	OS enters progress note in CPRS for regular consult; OS and DS enter progress notes for follow-up consults
5b	- Record code for billing	DS adds non-count CPT 99499 and ICD-9 codes and appropriate CPT modifier GQ (for Store & Forward Telemedicine – professional component) to CPT
5c	- Record for workload credit	DS pairs 693 Secondary stopcode (aka credit pair) with Primary stopcode appropriate to clinic
6	Do not bill for non-count clinic	Unlike real-time telemed, DS does not bill (3rd party only) for telemed non-count clinic
6a	- Do not bill 1st party co-pay	Unlike real time telemed, OS does not bill 1st party co-pay; this is a non-count clinic
6b	- Do not bill 3rd party for professional fee	Unlike real-time telemed, DS does not bill 3rd party for professional fee; this is a non-count clinic
7	Document any additional (same patient same day) encounters	DS completes patient encounter form for multiple visits on one day by one patient

APPENDIX 14

Distant Site (Different STA 3 (Station Number)) Coding/Billing Instruction Summary for Store & Forward Other than Radiology Telemedicine

Distant Site (Different STA 3) Documentation Process for Reimbursement and DSS Workload Credit		
	Action	**Description**
1	Establish non-count clinic	DS (either VAMC or CBOC) establishes clinic including setting up encounter form in VISTA
2	Enter consult into DS CPRS and load OS patient in DS VISTA (with Inter-Facility Consult where available)	DS and OS IFC teams set up IFC to automatically load OS patient in DS VISTA, or auto-alerts trouble. If no IFC, OS and DS Telemed Coordinators load patients.
3	Register patient	If OS unable to access DS system, DS Med Admin Service (or IT staff) registers patient into DS system. DS coordinates with OS Telemedicine Coordinator
4	Provide consult or care for OS patient	DS provides consult or care to patient, presenter and or provider at OS
5	Document telemedicine non-count clinic	DS completes patient encounter form in CPRS. Where available, IFC auto-alerts OS that consult is complete and report (including DS provider identification) available for view in OS CPRS and checks patient out in Appointment Mgt for workload/reimbursement purposes
5a	- Update patient record	OS enters progress note in CPRS for regular consult; OS and DS enter progress notes for follow-up consults
5b	- Record code for billing	DS adds non-count 99499 CPT and ICD-9 codes and appropriate CPT modifier GQ (for Store & Forward Telemedicine – professional component) to CPT
5c	- Record for workload credit	DS pairs 693 Secondary stopcode (aka credit pair) with Primary stopcode appropriate to clinic
6	Do not bill for telemedicine non-count clinic	Unlike real-time telemed, DS does not bill (3rd party only) for telemedicine, since this is a non-count clinic
6a	- Do not bill 1st party co-pay	Unlike real-time telemed, OS does not bill 1st party co-pay; this is a non-count clinic
6b	- Do not bill 3rd party for professional fee	Unlike real-time telemed, DS does not bill 3rd party for professional fee; this is a non-count clinic
7	Document any additional (same patient same day) encounters	DS completes patient encounter form for multiple visits on one day by one patient

APPENDIX 15

Distant Site Coding/Billing Instruction Summary for Televideo Real-Time Home Telehealth Care

Distant Site Documentation Process for Reimbursement and DSS Workload Credit		
	Action	**Description**
1	Establish count clinic	DS establishes clinic including setting up encounter form in VistA
2	Enter consult into DS CPRS and load home telehealth patient in DS VistA	DS automatically loads patient data in DS VistA.
3	Register patient	DS Med Admin Service (or IT staff) accesses list of scheduled patients and schedules same list in DS VistA.
4	Provide consult or care for home telehealth patient	DS provides consult or care to patient or provider with patient at home
5	Document telemedicine count clinic	DS completes patient encounter form in CPRS and checks patient out in Appointment Management for workload/reimbursement purposes
5a	- Update patient record	DS enters progress note in CPRS for regular consult or follow-up consults
5b	- Record code for billing	DS enters CPT and ICD-9 codes in VistA, DS adds CPT and ICD-9 codes and appropriate CPT modifier GT (for Real Time Telemedicine – professional component) to CPT
5c	- Record for workload credit	DS pairs DSS Secondary stopcode (a.k.a. credit pair) 179 with Primary stopcode 685 for Care Coordination staff or other Primary stopcode appropriate to clinic (e.g., 171 for HBPC nurse)
5d	- Record for Care Coordination credit	DS uses the appropriate (clinical care-specific and provider-specific) Alpha Code (see Appdx 16.) to designate home telehealth episode
6	Bill for telemedicine count clinic	DS bills (3rd party only) for telemedicine count clinic
6a	- Never Bill 1st party co-pay	DS never bills 1st party co-pay
7	Document any additional (same patient same day) encounters	DS completes patient encounter form for multiple visits on one day by one patient

APPENDIX 16

Distant Site Coding/Billing Instruction Summary for Non -video Home Telehealth Intervention

Distant Site Documentation Process for Reimbursement and DSS Workload Credit		
	Action	**Description**
1	Establish count clinic	DS (either VAMC or CBOC) establishes clinic including setting up encounter form in VISTA
2	Enter consult into DS CPRS and load home telehealth patient in DS VISTA	DS automatically loads home telehealth patient in DS VISTA.
3	Register patient	DS Med Admin Service (or IT staff) schedules list of home telehealth patients in DS VISTA.
4	Provide consult or care for OS patient	DS intervenes with consult or care to patient or provider at home with veteran
5	Document telemedicine count clinic	DS completes patient encounter form in CPRS and checks patient out in Appointment Management for workload/reimbursement purposes
5a	- Update patient record	DS enters progress note in CPRS for regular consult or follow-up consults
5b	- Record code for billing	DS enters CPT and ICD-9 codes in VISTA
5c	- Record for workload	DS pairs DSS Secondary stopcode (a.k.a. credit pair) 684 with the Primary stopcode appropriate to clinical intervention
5d	- Record for Care Coordination credit	DS uses the appropriate (clinical care-specific and provider-specific) alpha code (see Appendix 16.) to designate home telehealth episode
6	Never bill for telemedicine non-count clinic	DS does not bill (3rd party only) for non-count telemedicine clinic
6a	- Never Bill 1st party co-pay	DS never bills 1st party co-pay
7	Document any additional (same patient same day) encounters	DS completes patient encounter form for multiple visits on one day by one patient

APPENDIX 17

Distant Site Coding/Billing Instruction Summary for (Non-Count) Non-video Home Telehealth Monitoring

Distant Site Documentation Process for Reimbursement and DSS Workload Credit		
	Action	**Description**
1	Establish non-count clinic	DS (either VAMC or CBOC) establishes non-count clinic including setting up encounter form in VISTA
2	Enter consult into DS CPRS and load home telehealth patient in DS VISTA	DS automatically load OS patient in DS VISTA, or auto-alerts trouble. If no IFC, OS and DS Telemed Coordinators load patients.
3	Register patient	DS Med Admin Service (or IT staff) schedules patient list in DS VISTA.
4	Provide consult or care for home telehealth patient	DS provides consult or care to patient or provider with patient at home
5	Document telemedicine count clinic	DS completes patient encounter form in CPRS and checks patient out in Appointment Management for workload/reimbursement purposes
5a	- Update patient record	DS enters progress note in CPRS for regular consult or follow-up consults
5b	- Record code for billing	DS enters CPT and ICD-9 codes in VISTA to CPT
5c	- Record for workload	DS records DSS Primary stopcode 683 no secondary stopcode (a.k.a. credit pair) required
5d	- Record for Care Coordination credit	DS uses the appropriate (clinical care-specific and provider-specific) alpha code (see Appendix 16.) to designate home telehealth episode
6	Never bill for non-count clinic	DS does not bill (3rd party only) for non-count telemedicine clinic
6a	- Never Bill 1st party co-pay	DS never bills 1st party co-pay
7	Document any additional (same patient same day) encounters	DS completes patient encounter form for multiple visits on one day by one patient

APPENDIX 18

Appropriate CPT Evaluation and Management (E&M) Codes for Telemedicine

Code	CPT-4 Description	Workload Count
Clinical Area, Professional Consultation Real ti me professional office visit or consultation in which there is real -time two-way audio and visual interaction between patient and provider.(Refer to CMS definition of telehealth services.)		
99201-99209	Office or other outpatient visit for the evaluation an d management of a new patient	Visit
99211-99215	Office or other outpatient visit for the evaluation and management of an established patient	Visit
99241-99245	Office consultation for a new or established patient	If the patient is co-located with one provider & a telehealth encounter is conducted with a provider at another place of care both providers may accrue a visit is the contribution of both meets the visit criteria. Otherwise occasion of service.
99251-99253	Initial inpatient consultation for a ne w or established patient	
99261-99263	Follow-up inpatient consultation for an established patient	
99271-99273	Confirmatory consultation for a new or established patient	
90804-90809	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility	Visit
90862	Pharmacologic management, including prescription use, and review of medication with no more than minimal medical psychotherapy	Visit
If Interaction Involves Telephone:		
99371-99373	Telephone call by physician to patient or for consultation of medical management or for coordinating medical management with other health care professionals (e.g., nurses, therapists, social workers, nutritionists, physicians, pharmacists.)	Visit or Occasion of Service, as appropriate
Telemedicine, Pre-Recorded Encounter [Store and Forward]		
99499	Unlisted evaluation and management service. To be used by privileged providers evaluating and providing advice on pre - recorded telemedicine encounters.	Occasion of service

APPENDIX 19

DSS Identifier Codes for Telemedicine/Telehealth

FOR HOSPITAL AND CLINIC TELEMEDICINE		
_ _ _690	TELEMEDICINE	**TELEMEDICINE.** Records, at the patient's site (originating site), telemedicine care provided to patients. Telemedicine is the use of electronic communications and information technology to provide and support healthcare when distance separates the participants. This secondary code can be attached to any primary stop code related to the workgroup that provides telemedicine consultations for many types of patient populations. (e.g. teledermatology for wound care management, telemental health for medication management, telegeriatric and extended care for vital sign monitoring, etc.) If the patient's site is the patient's home use 179 (for real-time video) or 684 (for nonvideo intervention) as the credit pair(secondary code) instead of 690. **Secondary Stopcode Use Only**
_ _ _692	TELEMED CONSULT SAME STATION	**TELEMED CONSULT SAME STATION.** Records, at the provider site, telemedicine care provided to patients where the site of the patient and the site of the provider share the same STA3 (Station Number) such as in the case of a CBOC and it's parent station. **Secondary Stopcode Use Only.**
_ _ _693	TELEMED CONSULT NOT SAME STATION	**TELEMED CONSULT NOT SAME STATION.** Records, at the provider site, telemedicine care provided to patients where the site of the patient and the site of the provider have different STA3 (Station Number). For example, VAMC to VAMC or CBOC of VAMC #1 and VAMC #2. **Secondary Stopcode Use Only.**
FOR HOME TELEHEALTH with CARE COORDINATION and OTHER PROGRAMS (e.g., Mental Health, SCI, HBPC, etc.)		
_ _ _179	HOME TELEVIDEO CARE	HOME TELEVIDEO CARE. Records workload by VA health care professionals using real-time videoconferencing as a means to replicate aspects of face-to-face assessment and care delivery to patients **IN THEIR HOMES**. Assessment and care may include: health/social evaluations, wound management, exercise plans, patient appearance, monitoring patient self-care, medication management, monitoring vital signs, including pain, etc. These telehealth encounters **must be electronically documented in CPRS** , fully meeting criteria for provider encounter. Use provider work-unit related stop as primary, e.g. 170179 – HBPC Physician doing TeleHome care, 323179 – TeleHome Primary Care, 502179 – TeleHome Mental Health. VA Medical Centers providing this care will have made significant investment in the staffing and technological infrastructure required to support such complex care provision in the home environment. Not Limited to HBPC. **Secondary Stopcode Use Only**
683_ _ _	HOME TELEHEALTH	Records MAS-non-count monitoring workload by VA health care professionals using non-video electronic in-home monitoring devices for the remote monitoring of patients on a regular basis and interpretation of patient's

	MONITOR ONLY NONVIDEO ***(Non Count)***	health care information received through electronic transmission as a means to replicate aspects of face-to-face assessment of patients **IN THEIR HOMES** using telehealth. Assessment may include: vital signs, self-care, pain management, wound management, medication management, health/social assessment, etc. VA Medical Centers providing this care will have made significant investment in the staffing and techno logical infrastructure required to support such complex care provision in the home environment. Not limited to HBPC. **Primary Stopcode Use Only**
_ _ _684	HOME TELEHEALTH INTERVENTION/ NONVIDEO	Records intervention resulting from a clinical change in the pat ient's condition revealed via HOME HEALTH MONITOR: stopcode 683 necessitating contact with the provider for resolution. This intervention constitutes a clinical encounter must be electronically documented in CPRS. Assessment and care include: vital signs , self-care, pain management, wound management, medication management, health/social assessment, etc. VA Medical Centers providing this care will have made significant investment in the staffing and technological infrastructure required to support such com plex care provision in the home environment. Not limited to HBPC. **MAS Count. Secondary Stopcode use only.**
_ _ _371	INITIAL EVALUATION/ ASSESSMENT of CC PATIENT	Records initial evaluation or assessment of patient for enrollment in a VHA Care Coordinatio n program. The evaluation/assessment may occur in a VHA facility or in the patient's private place of residence. **MAS Count. Secondary Stopcode use only.**
_ _ _685	CLINICAL STAFF ACTIVITY SUPPORTING VISN CARE COORDINATION PROGRAM	Records any activity/care (specified in the Primary Code) performed/provided by clinical staff in-person or via telehealth to support VISN's Care Coordination Program. **MAS Count.**
FOR CARE COORDINATION ONLY		
685_ _ _	CARE COORDINATION STAFF CLINIC	Records Care Coordination staff clinic providing the home telehealth activity/care specified in the Secondary Stop Code. **MAS Count.**
686	CARE COORDINATION STAFF TELEPHONE CONTACT	Records Care Coordination clinical staff contacted patient via telephone without any home telehealth activity/c are performed. No Credit Pair needed/used. **MAS Count**.

DRAFT DOCUMENT PLEASE DO NOT CITE OR CIRCULATE

APPENDIX 20

DSS Alpha Codes for Home Telehealth*

*For use by Care Coordination Service

CCS Clinical Care-Specific ALPHA CODES	Description
CD	Cardiac Disease
CG	Coagulation Management
DE	Dementia
DM	Diabetes Mellitus
HT	Hypertension
ID	Infectious Disease
MH	Mental Health
MM	Multiple CoMorbitities
PD	Pulmonary Disease
PL	Palliative Care
PM	Pain Management
RH	Rehabilitation
SC	Spinal Cord Injured
WC	Wound Care

CCS Provider-Specific ALPHA CODES	Description
MD	Medical Doctor
NP	Nurse Practitioner
RD	Registered Dietician
RN	Registered Nurse
SW	Social Worker
00	Undesginated (Individ or Team)

GLOSSARY

Term	Definition
Originating site	The site where the patient is located at the time the service is provided
Distant site	The site where the provider providing the professional service is located
Consultant	A clinician giving an opinion and/or advising another clinician who is responsible for the patient
Interpretive Reader	A clinician offering an official reading of an image, tracing or specimen. This clinician might make a diagnosis and/or suggest a course of treatment, however, the clinician who is responsible for the patient makes the official diagnosis and treatment decisions.
Treating Clinician	A clinician who is using a telemedicine link and is responsible for all or part of the care of the patient.
CBOC	Community based outpatient clinic
VAMC	Veterans Administration Medical Center
VISN	Veterans Integrated Service Network
Referring clinician	The clinician responsible for the care of the patient at the originating site
DSS	Decision Support System – an executive information system that provides data related to patient care services and outcomes, staffing and costs to VHA and private sector healthcare organizations. DSS data is pulled from existing VHA data systems (e.g., Event Capture and Appointment Management)
DSS Stop Code	a.k.a DSS Identifier - Numeric identifier comprised of a pairing of a 3-digit Primary Stop Code and a 3-digit Secondary Stop Code.
DSS Primary Stop Code	3-digit code that designates the main Ambulatory Care Clinical Group or production unit responsible for the clinic.
DSS Secondary Stop Code	3-digit code (modifier) that designates the type of services provided or the type of provider or team providing the service, or it may designate a specially funded program.
Count Clinic	A clinic for which workload entered is credited
Non-Count Clinic	A clinic for which no workload is credited
MAS	Medical Administration Service a.k.a. Patient Information Management System (PIMS)
PIMS	Patient Information Management System formerly Medical Administration Service
HBPC	Home Based Primary Care
SCI	Spinal Cord Injury
DHCP	Decentralized Hospital Computer Program
ICD-9	Diagnosis Code – International Classification of Diseases (of the World Health Organization) – 9th Revision
CPT	Procedure Code – (aka CPT-4) Common Procedural Terminology 4th Edition – designates procedures or services provided to a patient.
CMS	Centers for Medicare and Medicaid Services
BCBSA	Blue Cross/Blue Shield Association
HIAA	Health Insurance Association of America

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